2017

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The American Health Care Act Would Toss the States a Hot Potato

by David Gamage and Darien Shanske

Health Care Act (AHCA) may still live, and that House Republicans may try again to pass this bill or something resembling it.

Because the major provisions and structure of the AHCA may be enacted in some future legislative effort, it is worth analyzing the implications that this would have for state-level tax and health policy. In this article, we argue that passage of the AHCA in anything like its current form would toss a hot potato to state governments by forcing them to act promptly if they are to save individual insurance markets in their states. This article explains the problem so that state-level policymakers can be prepared to act quickly if the AHCA is passed. The most promising state government responses to the AHCA would involve passing new state-level taxes and subsidies. Hence, state-focused tax policy communities should be prepared for state governments to act.

To assess the AHCA bill, it is helpful to think of it as consisting of four major buckets of reform:

- ending many of the ACA’s tax provisions;
- phasing in cuts to Medicaid funding and scheduling devolution of Medicaid to the states;
- transforming the ACA’s other major health subsidies from being based mostly on income and health costs to being based more on age; and
- making other changes to the ACA’s insurance market regulations.

This essay focuses on the fourth bucket — the changes to the ACA’s insurance market regulations other than the changes to subsidies. The AHCA’s Medicaid reforms would also create challenges for state governments, but explaining those challenges is not the topic of this essay.
What is most striking about the AHCA’s insurance market changes is how they keep nearly all the ACA’s reforms in place. Right-wing groups have thus called the AHCA “Obamacare lite.” Yet, in a sense, this is a misnomer. The AHCA’s changes do not really water down the ACA’s regulations, as the intended slur Obamacare lite implies. Rather, the AHCA’s changes would likely cause the ACA’s framework for regulating the individual market to fall apart — absent countervailing actions by state governments.

If the AHCA bill were enacted in its current form, the result would likely be adverse-selection death spirals. The only real hope for saving the individual market would be for state governments to step up with new state-level regulations for supporting insurance markets in their state.

The AHCA retains the ACA’s bans against insurance plans denying coverage or charging more to people with preexisting health conditions. This means that the individual market for health insurance would not function based on an actuarial fairness model, wherein people would be charged based on their expected future healthcare costs. Instead, the individual market would function based on a risk-pooling model.

Any risk-pooling model for health insurance needs mechanisms for coping with adverse selection. Absent those mechanisms, healthier Americans would likely opt for cheaper, more bare-bones health insurance plans, or to forgo purchasing health insurance altogether. This would then leave more comprehensive health insurance plans covering sicker and more costly populations, which would lead insurance companies to raise the prices on these plans or to restrict the benefits that are more attractive to sick insureds. The iteration of these dynamics generally leads to adverse-selection death spirals that can cause insurance markets to collapse into only bare-bones plans or even no plans at all.

The ACA dealt with these dynamics through the individual mandate, actuarial value requirements, essential health benefits requirements, other restrictions banning bare-bones health plans, and risk-adjustment systems that charge health insurance plans with less costly pools of insureds while compensating plans with more costly pools of insureds. Many argue that these ACA measures were insufficient and that adverse selection death spirals are beginning to develop in at least some states. To the extent that is correct, the only possible solutions are:

- some combination of toughening the penalties for going without insurance coverage and the restrictions on bare-bones insurance plan offerings or implementing stronger risk-adjustment and subsidization mechanisms to bolster more comprehensive insurance offerings; or
- moving away from the risk-pooling model and toward either an actuarial fairness model or a single-payer model.

Yet the AHCA does none of these. As noted, the AHCA continues to rely on the risk-pooling model by preventing insurance plans from charging more or denying coverage to insureds with preexisting conditions. Then, instead of strengthening the ACA’s provisions for limiting adverse selection, the AHCA dramatically weakens these provisions. Most notably, the AHCA replaces the ACA’s individual mandate with a (laughably lenient) continuous coverage requirement while also repealing the ACA’s actuarial value requirements and — in some later versions — essential health benefits requirements.

In other words, the AHCA would allow healthy people to purchase cheap, bare-bones insurance plans or to forgo purchasing insurance altogether. Then, when these people become sick and need greater coverage, they could switch to a

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3 Id. at 683-685.
more comprehensive health insurance plan, paying no penalty if they are switching from a bare-bones plan or paying just 30 percent more for a year if they are switching from no coverage.

This is simply not enough incentive for healthier people to purchase more comprehensive insurance plans from the individual market. If enacted, the AHCA would thus result in more comprehensive insurance plans being swamped with high-cost insureds with expensive health conditions, which would then create overwhelming pressure for insurance providers to either restrict the features of plans that appeal to high-cost insureds or withdraw from the market altogether. To illustrate, consider what insurance provider would want to create a plan that offers great cancer coverage, if the result would be to attract extremely high cost cancer patients, without being able to either charge them higher premiums or to otherwise be reimbursed for their greater cost?

Were the AHCA enacted in its current form, the best hope for saving individual insurance markets would be for state governments to step up and pass state-level regulations to make up for the AHCA’s weaknesses. Nothing currently prevents state governments from implementing their own individual mandates; or even better, state governments could directly subsidize exchange plans to make the individual mandate unnecessary, along with implementing better, state-level risk adjustment mechanisms.

Before discussing how state governments should respond to the AHCA, it is worth reiterating that the AHCA is a draft bill and its framework could be made workable without state government action. Joseph Antos and James Capretta explain one way this could be done. Their proposed approach would involve, among other measures, greatly increasing the continuous coverage requirement penalties. They write:

The AHCA penalty imposed on persons who experience a break in their insurance enrollment of more than two months in the prior year would be a 30 percent premium surcharge payable for 12 months. For a plan costing $6,000 a year, that amounts to a surcharge of $150 a month. Healthy consumers are likely to take their chances, saving that $6,000 in the hope that they would not incur significant medical expenses during the year. With the repeal of the individual mandate, and the retention of the ACA’s insurance rules, the overall effect would be significant market turbulence, starting immediately in 2017. To avoid a complete collapse of the market, the AHCA should provide a strong and clear penalty for persons who exit the market, covering multiple years. One approach would be to extend the current surcharge over several years. Another possibility would be to impose a waiting period before benefits would be paid.

More generally, the AHCA may not pass or may be so substantially revised by the time it passes so as to resolve the problems we identify in this article. But there is a non-trivial risk of the AHCA passing in something like its current form. So state governments and state tax policy communities should be prepared to act if needed.

Perhaps the most straightforward option for how state governments could respond to the AHCA would be to legislate state-level individual mandates. Indeed, health law scholar Nicholas Bagley has proposed just that. In an op-ed focused on California, he wrote:

For 2018 and 2019, almost every part of Obamacare except for the individual mandate will remain intact. California can patch that hole by replacing the individual mandate at the state level. Call it the Golden State Mandate. The Legislature would have to act fast. The substitute mandate probably would have to be in place by the summer in order to give insurers time to set their rates before the start of open enrollment on Nov. 1. Even then, the gambit might not work: Insurers are skittish about the long-term future of health reform. Some may head for the hills. But the California exchange is healthy and, with a substitute mandate in place, the economic picture for the next two years shouldn’t look all that different than it does today. Instead of the premium surge that other states will experience, California

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residents could see a more moderate increase in premiums. At a minimum, it’s worth a shot.7

Bagley’s proposal for state-level individual mandates could work, at least in theory. Yet the individual mandate has always been among the least popular of the provisions in the ACA framework. Even the Obama administration was lukewarm about enforcing the mandate and was arguably unwilling to give it sufficient teeth. We are thus skeptical that state governments would have the political will to successfully implement this approach — even in California.8

So what might state governments do instead? The best solution would probably be to implement state-level versions of the ACA’s reinsurance and risk corridor programs but to make them permanent, in contrast to their temporary, transitional role in the ACA regulatory framework.9 This approach would involve levying taxes on group and self-funded health insurance plans and on individual health plans with healthier, lower-cost pools of insureds, and then using these funds to compensate individual health plans that attract higher-cost pools of insureds for the excess coverage costs.10

Implementing state-level reinsurance and risk corridor programs would not be simple. Nor would implementing any alternative approach capable of saving individual insurance markets in the states. Preparatory work would probably need to be started even before the AHCA became law. Some issues that would need to be worked through include:

• ensuring that the overall subsidization of exchange plans (or other individual market plans) would be sufficient to make up for the lack of an individual mandate;
• managing the likely erosion of employer-sponsored coverage that would result from the subsidization of individual market plans in the absence of an employer mandate;11 and
• designing anti-fraud and anti-gaming mechanisms to limit the potential for insurance providers to manipulate the new programs against the public interest.

Will state governments be up to managing these challenges? If the AHCA is not passed, we may never know. If the AHCA does pass, we can only hope. No doubt the states have bought some time with the collapse of the AHCA repeal effort, but this reprieve may only be temporary. There are also indications that the administration may undermine the ACA through administrative action, which means that the states may end up with the same hot potato even without formal repeal of the ACA.12 We therefore believe that it is crucial for state tax policy communities to begin preparatory work soon.13 Only through such action will state governments be able to handle the hot potato tossed to them by the federal government without being burned.

8 There have been serious efforts to establish a single-payer system in California in the past and similar discussions have begun again. See, e.g., Soumya Karlamangla, “With Obamacare in Jeopardy, California Considers Going It Alone With ‘Single-Payer,’” Los Angeles Times, Feb. 26, 2017.
10 An alternative approach that should also be considered would be to implement a state-level high-risk pool in a manner designed to achieve the result of subsidizing more comprehensive individual market plans. Maine’s experience in 2011 offers a model for how this could be done. For discussion, see Joel Allumbaugh, Tarren Bragdon, and Josh Archambault, “Invisible High-Risk Pools: How Congress Can Lower Premiums and Deal With Pre-Existing Conditions,” Health Affairs Blog (Mar. 3, 2017).
11 See Hemel, “The House GOP Plan and Employer-Sponsored Health Insurance: Killing It Softly?” Whatever Source Derived Blog (Mar. 10, 2017), for preliminary analysis on this issue. See Gamage, supra note 2, at 692-693, for a discussion of this issue under the ACA. A major reason why federal policymakers were concerned about the potential erosion of employer-sponsored coverage when legislating and implementing the ACA was that it could have dramatically driven up the budgetary cost of the exchange subsidies. From a state government perspective, were the AHCA to be passed and implemented, this would arguably be a plus, since the more that state government policy shifted insureds from employer-sponsored coverage to subsidized individual market coverage, the larger the subsidies the federal government would provide to the state and the stronger the state’s individual market would likely become (at the federal government’s expense).
13 We plan to return to the topic with some ideas and observations in a future essay.